



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-844-453-4508.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$750 Individual/ \$1,500 Family for Preferred Providers. \$1,500 Individual/ \$3,000 Family for Non-Preferred Providers. Preferred Provider and Non-Preferred Provider deductibles are combined. Satisfying one helps satisfy the other.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$1,500 Individual/ \$3,000 Family for Preferred Providers. \$3,000 Individual/ \$6,000 Family for Non-Preferred Providers. Preferred Provider and Non-Preferred Provider out-of-pocket are combined. Satisfying one helps satisfy the other.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Penalties incurred for failing to obtain precertification/utilization review, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.anthem.com or call 1-844-453-4508 for a list of Preferred Providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.anthem.com or call 1-844-453-4508 to request a copy.

Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Preferred **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$50 Copay/Visit	40% After Deductible	-----none-----
	Specialist visit	\$50 Copay/Visit	40% After Deductible	-----none-----
	Other practitioner office visit	Chiropractor \$50 Copay/Visit Acupuncturist \$50 Copay/Visit	Chiropractor 40% After Deductible Acupuncturist 40% After Deductible	Chiropractor Coverage is limited to 40 visits maximum per Benefit Period. Acupuncturist -----none-----
	Preventive care/screening/immunization	No Cost Share	40% After Deductible	-----none-----

If you have a test	Diagnostic test (x-ray, blood work)	20% After Deductible	40% After Deductible	Pre-certification required for Non-Preferred Providers: Diagnosis of Sleep Disorders, Gene Expression Profiling for Managing Breast Cancer Treatment and Genetic Testing for Cancer Susceptibility.
	Imaging (CT/PET scans, MRIs)	20% After Deductible	40% After Deductible	Pre-certification required for Non-Preferred Providers: MRI Guided High-Intensity Focused Ultrasound Ablation of Uterine Fibroids.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.anthem.com	Generic Formulary Drugs	\$10 Copay/Prescription fill for Retail Pharmacy \$20 Copay/Prescription fill for Mail Order	Not Covered	Up to 90-day supply for Retail Pharmacy (copay applied per 30-day supply). 90-day supply for Mail Order.
	Brand Name Formulary Drugs	\$60 Copay/Prescription fill for Retail Pharmacy \$120 Copay/Prescription fill for Mail Order	Not Covered	Up to 90-day supply for Retail Pharmacy (copay applied per 30-day supply). 90-day supply for Mail Order. If a Generic is available, a Participant who elects to use a Brand Drug as a matter of preference will be responsible for the difference in cost between the Brand and the Generic Prescription.
	Brand Name Non-formulary Drugs	\$100 Copay/Prescription fill for Retail Pharmacy \$200 Copay/Prescription fill for Mail Order	Not Covered	Up to 90-day supply for Retail Pharmacy (copay applied per 30-day supply). 90-day supply for Mail Order. If a Generic is available, a Participant who elects to use a Brand Drug as a matter of preference will be responsible for the difference in cost between the Brand and the Generic Prescription.
	Specialty Drugs	\$200 Copay/Prescription fill for Mail Order	Not Covered	-----none-----

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% After Deductible	40% After Deductible	-----none-----
	Physician/surgeon fees	20% After Deductible	40% After Deductible	-----none-----
If you need immediate medical attention	Emergency room services	\$250 Copay/Visit	\$250 Copay/Visit	Pre-certification required for Emergency Admissions by Non-Preferred Providers (requires Plan notification no later than 2 business days after admission).
	Emergency medical transportation	\$100 Copay/Trip	40% After Deductible	-----none-----
	Urgent care	\$50 Copay/Visit	40% After Deductible	Other cost shares may apply depending on services provided.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% After Deductible	40% After Deductible	-----none-----
	Physician/surgeon fee	20% After Deductible	40% After Deductible	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit \$50 Copay/Visit	Office Visit 40% After Deductible	Mental/Behavioral Health Office Visit -----none----- Mental/Behavioral Health Facility Visit– Facility Charges Pre-certification may be required for Non-Preferred Providers after initial twelve (12) visits. Call for details.
	Mental/Behavioral health inpatient services	20% After Deductible	40% After Deductible	-----none-----
	Substance use disorder outpatient services	Office Visit \$50 Copay/Visit	Office Visit 40% Coinsurance	Substance Abuse Office Visit -----none----- Substance Abuse Facility Visit – Facility Charges Pre-certification may be required for Non-Preferred Providers after initial twelve (12) visits. Call for details.
	Substance use disorder inpatient services	20% After Deductible	40% After Deductible	-----none-----

If you are pregnant	Prenatal and postnatal care	20% After Deductible	40% After Deductible	-----none-----
	Delivery and all inpatient services	20% After Deductible	40% After Deductible	Pre-certification may be required for OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay) at Non-Preferred Providers. Call for details. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home health care	20% After Deductible	40% After Deductible	Coverage is limited to 100 visits maximum per Benefit Period.
	Rehabilitation services	20% After Deductible	40% After Deductible	-----none-----
	Habilitation services	20% After Deductible	40% After Deductible	-----none-----
	Skilled nursing care	20% After Deductible	40% After Deductible	Coverage is limited to 90 days maximum per Benefit Period.
	Durable medical equipment	20% After Deductible	40% After Deductible	Pre-Certification may be required for Non-Preferred Providers. Call for details.
	Hospice service	20% After Deductible	40% After Deductible	Coverage is limited to 365 visits or 365 days for Lifetime Maximum combined for Inpatient and Outpatient Hospice care.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Covered under separate Vision Plan. Refer to VSP Benefit Summary.
	Glasses	Not Covered	Not Covered	Covered under separate Vision Plan. Refer to VSP Benefit Summary.
	Dental check-up	Not Covered	Not Covered	Covered under separate Dental Plan. Refer to Description of Dental Benefits in Plan Document.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care (unless you have been diagnosed with diabetes; consult your Plan Document)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Acupuncture
- Private-duty nursing
- Hearing aids (one per ear per 60-month period)
- Non-surgical weight loss programs
- ABA Therapy (20 hour per week maximum)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-844-453-4508. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

State of Indiana Department of Insurance
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204
(800) 622-4461 or (317) 232-2395

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwoł íínízinigo t'áá diné k'éjígó, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagí bich'í hodiilní. Hai'daą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígí ní béesh bee hane'í wólta' bi'ki si'níilígí bi'kéhgo bich'í hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$5,890
- **Patient pays:** \$1,650

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$750
Copays	\$0
Coinsurance	\$750
Limits or exclusions	\$150
Total	\$1,650

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$3,820
- **Patient pays:** \$1,580

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$750
Copays	\$600
Coinsurance	\$150
Limits or exclusions	\$80
Total	\$1,580

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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